Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Bone & Joint Center

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-14-2324-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Procedure code 99080 Special Report/Work Status DWC-73 was denied in error for "no change in work status and/or restrictions; reimbursement denied per rule 129.5."

Amount in Dispute: $212.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed its claim file and there is no evidence that the carrier or employer requested additional DWC-73 per Rule 129.5 (d)(3) and the requester did not document a change in the employee's work status or activity restriction from the status/activity indicated on the preceding DWC-73."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 3, 2014	99213, 99080	$212.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.5 sets out guidelines for work status reports.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 248 – DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support the injured worker have a change in work status?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 248 – "DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied." 28 Texas Administrative Code §129.5 (3) "change in work status" means a change in the employee's work status from one of the three choices listed in subsection (a)(4) of this section to another of the choices in that subsection; and (4) the term "work status" refers to whether the injured employee's (employee) medical condition: (A) allows the employee to return to work without restrictions (which is not equivalent to maximum medical improvement); (B) allows the employee to a return to work with restrictions; or (C) prevents the employee from returning to work and (d) The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee."

   Review of the submitted documentation finds;

   a. Work status report shows return to work as of 10/30/13 without restrictions
   b. Work status report from 1/3/2014 shows return to work 1/3/14 without restrictions
   c. Physical Exam note; "Recommendation: (1) As patient is much improved in the knee and lower back, we will continue conservative care. (2) Refilled medication. (3) Continue home exercise program. (4) Continue hinged knee brace to the right knee as needed. (5) DWC-73 form was filled out. Patient is working full time without any problems."

   Documentation did not support that there was a change in work status as defined by Division rules nor was there documentation to support a request was made by the carrier, its agent or the employer. The Carrier's denial is supported.

   Procedure code 99213, service date January 3, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.002 is 0.97194. The practice expense (PE) RVU of 1 multiplied by the PE GPCI of 0.987 is 0.987. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.799 is 0.05593. The sum of 2.01487 is multiplied by the Division conversion factor of $55.75 for a MAR of $112.33. The total allowable reimbursement for the services in dispute is $112.33. This amount less the amount previously paid by the insurance carrier of $112.33 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.
2. Requirements of Rule 129.5 were not met no additional payment can be recommended. Carrier paid the professional service at Maximum Allowed Reimbursement (MAR).

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 19, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.